VARIOUS PERSPECTIVES ON PARENTING AND THEIR IMPLICATIONS FOR THE TREATMENT OF DISSOCIATIVE DISORDERS

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ABSTRACT

The parent-child dyad has been an underutilized resource for clinicians who treat individuals with dissociative disorders. This article examines the functions of the parent from the perspectives of various fields of knowledge: psychodynamic psychotherapy, attachment theory, infant development, affect theory, and family systems. It then elaborates on how dissociative symptoms may interfere with the normal processes of parenting and child development. Finally, it points out that there are a number of advantages to dealing with the parenting subsystem of the family of dissociative disorder individuals. Sensitizing clients to their own parenting can serve to benefit the therapeutic alliance as well as help the client/parent improve the parent-child relationship. This work has the potential both to aid in the recovery of the individual dissociative client and to begin to correct the transgenerational exploitation and mistrust which cause and perpetuate dissociative pathology.

INTRODUCTION

A number of authors have elaborated on the etiology of dissociative disorders, especially multiple personality disorder (MPD) and allied forms of dissociative disorder not otherwise specified (DDNOS) (Kluft, 1984a, 1984b; Kluft, Braun & Sachs, 1984; Braun & Sachs, 1985; Fink, 1988; Albini & Pease, 1989; Barach, 1991; Liotti, 1992) and reflected on their transgenerational transmission (Kluft, 1984b; Braun, 1985; Coons, 1985). Some have tried to determine the kind of parenting that leads to the development of a dissociative disorder. Kluft, Braun, and Sachs (1984) characterized the parents of children who develop MPD as inconsistent, unempathic, and out of touch with the developmental needs of children. Kluft (1984a, 1984b), in the final factor of his Four-Factor Theory of Etiology, addressed how the parents contribute to the formation of dissociative pathology in their child by failing to provide stimulus barriers and restorative experiences to the traumatized child. Albini and Pease (1989)

also saw parenting functions as vital factors in determining whether or not a child develops a cohesive self. Barach (1991) and Liotti (1992) studied the attachment literature in an effort to understand the development of dissociative pathology. Although they diverged in their conclusions, they both linked the kind of parenting that the child experienced to the formation of different patterns of insecure attachments.

Finally Kluft (1987), in a seminal investigation of the parenting of mothers who had MPD, took the first step in the actual study of dissociative parenting. In that article, he concluded that 61.3% of the seventy-five women in his sample were either compromised/impaired or grossly abusive as parents. He tabulated the types of pathological parenting, many of which included symptoms or behaviors characteristic of patients with MPD.

This paper endeavors to further these pioneering efforts in the area of parenting. It looks at some of the functions of the primary caregiver (the person who is principally responsible for the care of the child and who is usually, but not always, the mother), several theories of parent-child relationships, how a dissociative parent may impact the development of his or her child, and how the parent-child unit of the family can be utilized as a potent resource in the therapy of the dissociative client.

FUNCTIONS OF PARENTING

Psychodynamic Ideas

The psychodynamic literature represents a vast treasure house of wisdom and clinical insights. In a brief paper, however, it is impossible to completely represent the full range of rich (yet often conflicting) views formulated by psychoanalytic thinkers over many years. Therefore, we are only able to address selected ideas.

Freud (1938) himself saw the child's mother as the paramount love-object and the relationship between mother and child as the basis for future relationships. Moreover, he (Freud, 1914) viewed parenting as a revival of the adult's childhood narcissism. Benedek (1959) further elaborated on that theme, characterizing parenthood as a continuation of personality development beyond adolescence. She believed that at every psychosexual milestone in a child's development, the parent has an opportunity to rework earlier developmental experiences and conflicts in a new way: during pregnancy (Benedek, 1970b; Jessner, Weigert, & Foy, 1970), infancy (Winnicott, 1970), the separation-individuation period (Mahler, Pine, & Bergman, 1970), the Oedipal period

(Anthony, 1970a), latency (Kestenberg, 1970), and adolescence (Anthony, 1970a). Each critical period of development in the child has the potential to reactivate related developmental conflicts in the parent. The parent then has an opportunity either to resolve the conflict and further develop the personality or to not face the conflict—which might result in a pathological outcome. Galinsky (1981) later built upon the idea of stages of parenthood in a study in which she interviewed 228 parents in a search for common developmental tasks and themes.

Benedek (1959, 1970a) saw introjection, identification, and imitation not only as processes that help to shore up the psychic structures of the baby in the mother-baby dyad, but as processes that serve the maturation of the caregiver's psychic structures as well. For example, when the infant introjects and identifies with the "good" mother who satisfies his drive for food, the baby internalizes a mental attitude of "confidence" in Eriksonian (1963) terms, "basic trust." In a parallel fashion, the successful mother who satisfies her infant can introject and identify with the gratifying experience and feel self-confident about her mothering. If, through her positive mothering, she achieves a resolution of earlier conflicts with her own mother, then she manages a new integration in her own personality. The mother's ability to nurture her child results from the identification with and introjection of her own mother. These themes were examined by Chodorow (1978) in her feminist book which explores how "mothering is reproduced across generations" (p.3).

According to Benedek (1959, 1970a), the process of imitation is also a mutual interaction between child and parent. When the baby imitates positive patterns of the caregiver, the parent can then imitate the baby's imitations in an affirmative spiral of interaction. On the other hand, when the baby imitates negative patterns, the parent can either change her own behavior (thereby changing the baby's behavior) or not change her behavior. If she does not change her negative behavior, she maintains a negative interaction, and she may reject and find unlovable that part of the child that imitates her.

Imitation is often understood as a forerunner of true ego identification. Benedek (1959) believed that A. Freud's (1936) "identification with the aggressor" is a person's infantile imitation of the aggressor. This defense serves to help master emotions experienced in traumatic situations. Fraiberg, Adelson, and Shapiro (1975) elucidated this concept of "identification with the aggressor" in their classic article "Ghosts in the Nursery." There, they detailed how parents unconsciously inflict the actions of their childhood betrayers on their own children.

While Benedek (1959, 1970c) looked at the synchrony between the growth of parenthood and the child's psychosexual development, other psychodynamic theorists concentrated more on the specific functions of the parent. Winnicott (1965) established the concept of the "good enough mother" who facilitates the growth and continuity of the healthy ego in the child through protection, satisfaction of physiological needs, reliability, and empathy. He warned that failures in the "holding environment" could lead to "frag-

mentation of being [in the baby]. The infant whose pattern is one of fragmentation of the line of continuity of being has a developmental task that is, almost from the beginning, loaded in the direction of psychopathology" (1963, pp. 60-61).

Elson (1984), using the concepts of Heinz Kohut, differentiated between the main "task" of parenthood and the "process" of parenthood. She believed that the parent's task is to support the formation of healthy narcissism in the developing child. The parent supplies support through empathically mirroring, merging, confirming, and guiding the child's forming self. The parent as selfobject to the child allows the child to transmute the parent's responsiveness into the child's own developing psychic organization. At the same time, the caretaking functions also transform the psychic structure of the parent.

Ornstein (1981) also saw selfobject functions as occurring in a dual way between parents and children: the parents perform selfobject functions for their children while the children perform selfobject functions for the parent. In that latter process, the parent consolidates the "parental self." The process of parenthood, in fact, can be seen as the continuing transformation of the parent's own narcissism through "maturing parental empathy, wisdom, and acceptance of human transience...while moving toward a less central position in the lives of their children" (Elson, 1984, p. 312).

Many of the psychodynamic (and self-psychological) authors (Winnicott, 1965; Benedek, 1970a; Paul, 1970; Kohut, 1971; Ornstein, 1981) saw empathy as a key element in parenting. Paul (1970) clarified the concept of parental empathy:

> Empathy... presupposes the existence of the object as a separate individual, entitled to his own feelings, ideas, and emotional history. The empathizer makes no judgements about what the other *should* feel, but solicits the expression of whatever he *does* feel and, for brief periods, experiences these feelings as his own. (pp. 340-341).

Kohut (1971) believed that empathic failures in parents result in self pathology in patients.

While many authors presume mothers are the primary caregivers to children, Benedek (1959, 1970d) was careful to look at "fatherliness" as well as "motherliness." She concluded that there were two sources of fatherliness: biological bisexuality and the father's earlier biological dependency on the mother. Fathers, like mothers, through interactions with their children, have the potential to continue consolidating the personality. Finally, Fisch (1984) noted that the parenting experience itself can be utilized to build a therapeutic alliance. A focus on a client's relationship with her child is a non-threatening way to direct the client to examine libidinal and developmental material.

Attachment Ideas

Bowlby's (Bowlby, 1969, 1973, 1980, 1988; Ainsworth,

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Blehar, Waters, & Wall, 1978) attachment theory drew from ideas in a number of fields: psychoanalysis, ethology, psychobiology, cognitive development, and control systems theory. He explained that under normal circumstances a reciprocal behavioral system—attachment behavior in the child and maternal behavior in the parent—operates in order to preserve proximity to and protection of the infant. Such a system ensures the survival of the species. Attachment behaviors can be activated under certain conditions: absence or distance from the caregiver, return of or leaving of a caregiver after an absence, lack of responsiveness or rejection by the caregiver, distressing events, and internal conditions such as hunger or illness (Ainsworth et al., 1978).

Ainsworth and others (Ainsworth, 1982, 1985a, 1985b; Ainsworth et al., 1978; Main & Solomon, 1986; Parkes & Stevenson-Hinde, 1982; Sroufe & Fleeson, 1986) carried on the work of Bowlby in their identification of types of attachment in children: secure, anxiously avoidant, and anxiously resistant. In the context of the evolving parent-child relationship, over a period of time the child develops certain expectations of the parent. These expectations, or mental constructions that form the basis of personality, are called working or representational models (Bowlby, 1980, 1988). They include affective as well as cognitive components (Bretherton, 1985; Zeanah & Zeanah, 1989; Alexander, 1992), and they determine the child's expectations about both the availability of care by significant others and about the child's own worthiness for care (Sroufe, 1988).

Secure babies develop a working model of their mothers as responsive and accessible. Anxious-resistant babies build up a working model of their mothers as inconsistently accessible. Anxious-avoidant babies develop a working model of their mothers as rejecting, and they try to shield themselves through defensive detachment. Main and Solomon (1986; 1990) discovered a fourth classification of attachment: insecure-disorganized/disoriented. One of the most prominent features of this behavior in the child is a dazed demeanor accompanied by a "dead stare, a limp mouth, and a still body" (Main & Solomon, 1986, p. 120), characteristics that are reminiscent of a trance state. The parents of these children are characterized by unresolved traumas from childhood (Main & Cassidy, 1988; Main & Hesse, 1990).

Other researchers demonstrated that these attachments, without intervention, will persist throughout a person's life (Ainsworth, 1985b; Ricks, 1985; Collins & Read, 1990; Feeney & Noller, 1990). Main and her colleagues (cited in Ainsworth, 1985b; Main & Goldwyn, 1984; Main, Kaplan, & Cassidy, 1985; cited in Zeanah & Zeanah, 1989; Main & Hesse, 1990) developed an Adult Attachment Inventory in which they classified four main patterns of adult attachment: autonomous, enmeshed (or preoccupied), detached (or dismissing), and unresolved. The autonomous pattern is the counterpart of the child's secure attachment. Adults with this pattern are self-reliant, objective, and nondefensive. The enmeshed adults continue to be enmeshed in earlier relationships. Adults in the detached group remember little of early attachment relationships, tend to idealize their parents (even though anecdotal episodes contradict that picture), and tend to reject

attachment to others. Finally, the unresolved group is the counterpart of the disorganized/disoriented attachment in childhood. Although these adults may share some characteristics with any of the other three types, they are distinguished from the other groups by their confusion about past unresolved losses or traumas. The kinds of attachment that the parents demonstrate influence the subsequent attachment behavior of the child. The autonomous parents tend to rear secure children, the enmeshed parents tend to rear insecurely attached (although not strongly avoidant) children, the detached parents tend to rear anxious-avoidant children, and the unresolved parents tend to rear disorganized/disoriented children. Thus, a transgenerational pattern of attachment began to be discerned (Main & Goldwyn, 1984; Ricks, 1985; Sroufe & Fleeson, 1986; Zeanah & Zeanah, 1989; Main & Hesse, 1990).

The implications of attachment theory for parenting are many. The responsive parent tends to imbue the child with a secure attachment and provide a "secure base" (Bowlby, 1988) from which the child can explore and develop. The inconsistently accessible or rejecting parent tends to rear an anxiously attached child. Such a parenting stance could lead to a negative parent-child relationship with a high risk of child maltreatment (DeLozier, 1982; Main & Goldwyn, 1984; Schmidt & Eldridge, 1986; Aber & Allen, 1987; Sroufe, 1988; Barach, 1991).

Barach (1991) saw a detached (avoidant) pattern of attachment as a first step toward the development of a dissociative disorder. Liotti (1992) differed from Barach in that he conceived the disorganized/disorienting pattern as predisposing the child to dissociation as a defense. Because of the parent's alternating frightened and/or frightening stance toward the child, the child may develop numerous contradictory self-caregiver constructs. For example, when the parent behaves in a frightened way, the child may see the parent as helpless or distressed and himself as threatening or rescuing. Or, the child may see the parent as neglecting and himself as unlovable. When the parent is aggressive and frightening, the child may see the parent as threatening and himself as helpless.

Finally, Rutter (1974), who studied maternal deprivation, noted that the main attachment figure for a child did not need to be a biological parent, and it did not even need to be a female. Moreover, a child could develop multiple attachments.

Daniel Stern's Ideas on the Parent-Infant Dyad

Fink (1988) was the first to offer a developmental perspective to the etiology of MPD based on applications of the ideas of Daniel Stern (1985). Stern placed the growth of a person's self within a relationship context from the moment of birth. He elaborated four senses of self that continue to grow and exist throughout the lifespan: the emergent self (birth to two months), the core self (two to six months), the subjective self (seven to fifteen months), and the verbal self (fifteen months and later).

According to Stern (1985), the role of the caregiver in the development of these various senses of self is of great

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importance. The mother brings her own personal history with its working models into each interaction with the infant. Early on, the parent interacts socially with the baby in the service of physiological regulation. At the same time, the parent attributes intentions to the baby and treats him as an already developed person (Stern, 1985; Cramer, 1986). Parents exaggerate their social behaviors with baby talk or overstated facial expressions aimed at the infant so that the infant gives maximal attention to the parent. Through fine-tuned mutual regulation of arousal, infants get experience with self-regulation of stimulation. Similar to behaviors that excite the baby in social play, parents also exaggerate soothing behaviors to calm a distressed baby. The parent, who regulates the infant's self-experience, becomes a self-regulating other for the child. The many interactions with the parent are represented mentally by the infant as "Representations of Interactions that have been Generalized (RIGs)" (Stern, 1985, p. 97). Activation of the RIG becomes the memory of the interaction, and it is accompanied by an "evoked companion"—the experience, either in or out of awareness, of being with a self-regulating other (Stern, 1985, p. 112).

Additionally, the caregiver shares affective states with the baby through a process called "affect attunement" (Stern, 1985, pp. 138-161). Unlike empathy, which is mediated by cognitive processes, affect attunement is a more automatic matching of affect state through intensity, timing, or shape.

In the detailed description of the parent-infant interpersonal experience, Stern emphasized the parent's role as a finely-tuned instrument that is sensitive to the behaviors, affect states, and vocalizations of the baby.

Affect Theory

Like Stern (1985), many other theoreticians and observers of child development (Brazelton & Yogman, 1986; Demos, 1986; Tronick, Cohn, & Shea, 1986; Radke-Yarrow, 1986; Nathanson, 1993; Kelly, 1993) viewed the caregiver as the essential and critical regulator of affective states in children. Affects are innate, physiologically based, and operate as amplified analogues of a stimulus' gradient and intensity (Tomkins, 1962, 1963, 1991, 1992; Demos, 1986; Nathanson, 1992; 1993). According to Tomkins, affect influences a person's memory, perception, thought, and drives (cited in Demos, 1986).

Affect itself is most visible on the face (Demos, 1986; Nathanson, 1992, 1993; Tomkins, 1962, 1963, 1991, 1992), and caregivers send messages to children via their facial expressions (Bugental, Cortez, & Blue, 1992; Camras et al., 1990; Clyman, Emde, Kempe, & Harmon, 1986; Kopp, 1989) which may give children information to process, activate behavior in the children, or serve to spread the caregiver's affect to children (affect contagion) (Maccoby & Martin, 1983; Miller, Eisenberg, Fabes, Shell, & Gular, 1989; Bugental et al., 1992).

Similar to Stern (1985), Nathanson (1993) believed that the affective system mediates relatedness. Parents, through their ministrations to children, teach self-soothing and affect regulation. When a parent repeatedly relieves a child's distress, the child eventually learns "that *affect is the link between need, its identification, and its later relief* (Nathanson, 1993, p. 551)." Such interactions facilitate the child's learning to trust the information that his emotions give him. When there is a breakdown in the reciprocal regulatory system either through neglect or abuse of the child by the caregiver, affective disturbances may occur. The unsoothed and/or hurt child may develop low self-esteem or depressive states, demonstrate pathological defenses (such as avoidance, hypervigilance, denial, projection, splitting), and engage in self-destructive or aggressive behaviors (Green, 1981). Moreover, the biological damage to the affective regulating systems may be lasting in children whose central nervous systems are still in the process of developing (Van der Kolk, Perry, & Herman, 1991).

A major task of parenting is the socialization of children. Especially as children begin to socialize with peers and other adults, parents begin to think about how to help children achieve emotional control (Kopp, 1989). One of the goals of socialization becomes the regulation of affective arousal in appropriate ways (Maccoby & Martin, 1983).

Dix (1991), in a landmark article on the affective organization of parenting, posited that emotions are the heart of both effective and ineffective parenting. When the parent's affective system is sensitive and in tune with the child, competent child-rearing is promoted. However, when a parent's emotions are too strong, too weak, or out of tune with the child-rearing task at hand, parenting is undermined. Sensitivity to children's needs and parental warmth predict favorable developmental outcomes for children (Dix, 1991; Maccoby & Martin, 1983). Conflicts between parents and excessive negative emotion may contribute to distress in children and negative developmental outcomes (Dix, 1991; Radke-Yarrow, 1986). The stressors that may affect parents (e.g., marriage or employment) and the support systems that parents have to relieve stress influence parents' affective states. These factors bear on the quality of their parenting (Dix, 1991; Radke-Yarrow, 1986; Emery & Tuer, 1993). Chronic, severe, negative emotion in parents characterizes family dysfunction (Dix, 1991).

Dix postulated several reasons why negative emotion might dominate the affective state of the parents: 1) unrealistic expectations that the parents may have of their children; 2) faulty attributions that parents may make to the behaviors or misbehaviors of children; 3) parental focusing on self-needs rather than on the child's needs; 4) parental over-intrusiveness with a baby that may lead to gaze avoidance or protest in the child; 5) a sense of inefficacy in parenting.

It is evident that just providing information to children about how to regulate their affective responses is insufficient. Both the expression and regulation of the parents' own affect and the intensity of that expression teach children more about affect regulation than verbal instruction possibly can (Maccoby & Martin, 1983; Miller et al., 1989).

Parenting and Family Factors

The role of parents is to promote the developmental growth and emotional well-being of their children (Guttman, 1989). Healthy families have a clear hierarchy of power in

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which the parents are the leaders (Minuchin, 1974; Minuchin & Fishman, 1981). The parents respect the contributions of the children (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1984 & 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991) and empower them in appropriate ways as they grow (Nichols, 1988). Generational boundaries mean that parents carry different responsibilities, roles, maturity levels, and attitudes than children (Glick, Clarkin, & Kessler, 1987). The tasks of parenthood change as children pass through different developmental stages (Galinsky, 1987).

The family operates as a system such that problems in any part of the system affect the other parts. If either parent does not have a well-integrated sense of self, there is potential to triangulate a child into the marital relationship to fulfill certain needs in the parent or the marital dyad (Bowen, 1978; Slipp, 1988; Roberto, 1992). A parent can emotionally triangulate a child through the processes of splitting, projection, or projective identification (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Zinner & Shapiro, 1989; Roberto, 1992). Any of these processes may lead to overengagement with or rejection of a child, and they interfere with a child's growth.

When the hierarchy of leadership breaks down, parents may require that a child perform familial tasks that are not matched to his social, emotional, physical, or cognitive development. Such a process is called parentification, and it also interferes with normal growth and development. Boszormenyi-Nagy and colleagues (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Cotroneo, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991) took the idea of parentification of children and placed it in the ethical context of relational justice between parents and children. Parents who have been robbed of adequate parenting themselves may parentify their own children in an effort to rebalance the unfairness of their own childhood deprivation. Such an attempt to use the parent-child relationship as a substitutive context to balance out an unfair legacy is a destructive exploitation because it robs the child of a trustworthy relationship.

In a similar way, parents who have been exploited in childhood often seek to rebalance the old debts to them through substitutive retribution against their own children. This process is called "destructive entitlement" (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Cotroneo, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). The commonly heard phrase "my life was unfair, so why should my child's be any better?" captures the essence of this mechanism. Treating the child as the parent's debtor continues the cycle of familial injustice and further erodes trust reservoirs in the family.

Additionally, children are loyal to their parents because of their attachment bond (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). Parents compromise the emotional health of their child when they thrust the child into a split loyalty; that is, a position in which the child is forced to choose between embattled and hostile parents (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). A split-loyalty trap is an automatic parentification because it puts an unfair and confusing burden on the developing child.

PARENTING AND DISSOCIATIVE PARENTS

The parenting of individuals who have psychiatric illnesses has been a topic of intense interest to many investigators (Gunderson & Englund, 1981; Beardslee, Bemporad, Keller, & Klerman, 1983; Cytryn et al., 1984; Davenport, Zahn-Waxler, Adland, & Mayfield, 1984; Zahn-Waxler, McKnew, Cummings, Davenport, & Radke-Yarrow, 1984; Solnit & Leckman, 1984; Feldman & Guttman, 1984; Rutter & Quinton, 1984; Tronick & Gianino, 1986; Garrison & Earls, 1986; Lyons-Ruth, Zoll, Connell, & Grunebaum, 1986; Cohn, Matias, Tronick, Connell, & Lyons-Ruth, 1986; Beardslee & Podorefsky, 1988; DiNicola, 1989; Gordon, Burge, Hammen, Adrian, Jaenicke, & Hiroto, 1989; Guttman, 1989; Copans, 1989; Paris & Frank, 1989; Beardslee, Hoke, Wheelock, Clarke Rothberg, van de Velde, & Swatling, 1992; Goldman, D'Angelo, & DeMaso, 1993; Bezirganian, Cohen, & Brook, 1993). Fewer authors (Levenson & Berry, 1983; Kluft, Braun, & Sachs, 1984; Sachs, 1986; Kluft, 1985, 1986, 1987; Putnam, 1989; Williams, 1991; Benjamin & Benjamin, 1992, 1994a, 1994b) have looked at the obstacles to parenting in clients that have a dissociative disorder. Based on the foregoing discussion of the functions of parenting from numerous perspectives, we can summarize some of the essential ingredients for parenting that promote the growth of children. We can then examine how some of these functions get derailed in the context of the dissociative family.

Growth-Enhancing Parenting
Based on information from psychodynamic psychotherapy, attachment theory, child development, affect theory, and family systems, we can assemble a picture of the characteristics that might describe a healthy parent:

1) A person who meets the child's physiological, psychological, cognitive, and social needs;

2) A person who protects the child from the effects of both ordinary and extraordinary stresses and traumas;

3) A person who is loving and empathically attuned to the child;

4) A person who is not emotionally or physically intrusive toward the child;

5) A person who provides a "secure base" from which the child feels safe to venture forth, explore, and grow cognitively, socially, and emotionally;

6) A person who encourages the growth of the child's separate ego;

7) A person who tolerates a range of affects, knows how to modulate affect, and keeps negative affect to a minimum;

8) A person who is willing to grow and learn in the role of parent which includes examining the ways in which the person herself was parented;

9) A person who is willing to look at unrealistic expectations and attributions that are projected onto the child;

10) A person who is willing to work with a parenting partner in a cooperative way toward the best interest of the child;

11) A person who respects and encourages the contributions of the child without burdening the child with expectations that are inappropriate;

12) A person who socializes the child by teaching the norms of society;

13) A person who works to minimize stress and maximize support for herself so as to be strong and healthy enough to be available to the child.

DISSOCIATIVE PARENTING

In his article on the parental fitness of mothers with MPD, Kluft (1987) included mothers whose symptoms interfered with their parenting in the "compromised or impaired" category. The abusive mothers either failed to protect their children or physically or sexually violated their children. Of the abusive mothers, 75% were also psychologically abusive, and of the compromised/impaired group, 50% were psychologically abusive. Types of pathological parenting included: psychological abuse, involving children in behaviors that reflected their psychopathology (e.g. parentification); impairment due to amnesia; abdication of parenting by alters; physical attack by a parent's alters; intrusive overinvolvement; affective absence; absence due to prolonged hospitalization; and sexual seduction.

Dissociative disorders represent extreme disruptions of behavior, affect, sensation, and knowledge in individuals who have been severely and chronically traumatized in childhood (Braun, 1988a, 1988b). Elsewhere, we have noted that dissociation occurs within the context of the family when parents have either directly exploited their children or have been unresponsive and neglectful when their children were faced with overwhelming traumas (Benjamin & Benjamin, 1992). In our own clinical experience with dissociative clients, we have noted that various symptoms seem to get in the way of parenting (Benjamin & Benjamin, 1992, 1994a).

We will briefly comment on each of these symptom patterns.

Switching and Accompanying Behaviors

Switching from one state of consciousness to another is a psychobiological phenomenon that accompanies MPD. The switching is often accompanied by facial, postural, motor behavioral, speech, affective, cognitive, maturity level, and psychophysiological sensitivity changes (Putnam, 1988, 1989; Coons, 1988). It interferes with parenting in that it is disorienting and does not permit the parent to stay fully responsive to the child. "Rapid switching" leaves a parent extremely affectively labile with a series of inappropriate emotions. It is difficult to teach affective control to a child when the parent demonstrates the opposite.

Additionally, given children's very early attunement to the facial expressions of parents, the facial expressions that accompany switching may be confusing. As children adapt to the "normalcy" of switching behaviors, they may also imitate them. If the remaining factors of Kluft's (1984) Four-Factor Theory of causation are in effect, imitation may become a "shaping influence" in the potential development of MPD in the child.

Hearing Voices

Clients with MPD often complain of hearing many simultaneous voices in their heads, resulting in a great deal of internal confusion. Internal confusion works against attunement to the needs of the child.

Alter Personalities

Alter personalities originally occur as defensive responses to traumatic situations (Kluft, 1984a, 1984b; Putnam, 1989). Names, attitudes, and degrees of interawareness among alters may vary (Putnam, 1989). The amnesia among alters prevents consistent responsiveness to a child. Differing attitudes suggest that different alters may view themselves as having different relationships with the child. Some alters may deny being the child's parent. Others may play with the child in a childlike way. Some may dislike the child, while still others may wish to hurt or actually may hurt the child. Putnam (1989) noted that the children of MPD parents are very attuned to the alter states of the parents and can adapt to the switches. Levenson and Berry (1983) described a case in which the children of an MPD mother took advantage of her dissociation and encouraged switching to meet their own needs. We have worked with a client family in which the non-MPD child imitated in great detail the mother's switching into alternate personalities. Since her mother had insisted on the evaluation, the daughter complied by acting like her mother. She believed that one was supposed to have many "people" inside if one visited a therapist.

Kluft (1987) noted that alters sometimes parentify children by asking the children to perform tasks that are beyond their age-appropriate capabilities. At other times, alters encourage children to comply with alters' needs to the detriment of the children's own needs. Occasionally alters pay no attention to parental responsibilities and just leave home, giving their children too much autonomy and too little guidance.

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On the other hand, alters are sometimes overly intrusive in their child's activities. Some just go through the motions of parenting without any affective involvement, and others need hospitalization. We would add, based on our own observation, that the parental role is effectively abdicated when the hospitalizations are frequent and lengthy, or when the parent is absorbed in her own therapy to the exclusion of all else.

Cognitive Distortions

A number of authors have written about the cognitive distortions that occur as a result of repeated abuse (Fine, 1990; Fish-Murray, Koby, & van der Kolk, 1987; Briere, 1992). Such distorted thinking is not conducive to encouraging cognitive development in children. It models inflexibility and inability to reason, and it can lead to faulty expectations and attributions toward children.

Forgetting

Amnesia, a sudden inability to recall personal information, or more than normal forgetting, accompanies MPD and can get in the way of the most basic caregiving functions (American Psychiatric Association, 1994; Steinberg, 1993). Additionally, an inability to remember one's childhood history puts the parent at a distinct disadvantage for resolving past conflicts. Parents who do not have recall of hurtful events and their affective responses to them are at risk to repeat the past through the defensive process of "identification with the aggressor." In that way, they victimize their own children.

Detachment from Self and Others

Often a dissociative parent may experience depersonalization or derealization. In the former situation, the person may feel disconnected to the body. In the latter, the person may feel disconnected to the surroundings or the people around her. In either case, the person may feel out of control and detached from self and/or others. When this situation occurs in the presence of children, the parent can forget personal information about a child or not recognize a child. A very young child may easily become frightened, upset, or distraught if such a scenario occurs. The child may feel responsible to care for the parent. We speculate that if this situation is repeated frequently in a child's earliest years, it may contribute to an insecure attachment.

Self-Hurting

Individuals with MPD frequently engage in behaviors that hurt the body (Putnam, 1989; van der Kolk, Perry, & Herman, 1991; Briere, 1992). Parents may work actively to hide their self-mutilating inclinations and may succeed in doing so while a child is very young. But as children's cognitive abilities increase, their awarenesses usually do too. Children may be surprised, confused, upset, angry, or blame themselves when a parent hurts herself. If the child notices self-injurious behavior, the child may feel obligated to care for the parent. Alternatively, the child may dismiss it as another sign of a parent's "weirdness," detach from it, and ignore it. "Not notic-ing" is a safe way not to deal with it, although children, through identification and imitation, may unconsciously adopt self-hurting as a coping mechanism of their own.

Suicidality (van der Kolk, Perry, & Herman, 1991; Putnam, 1989) is another common way of hurting the self in individuals who have MPD. In addition to feeling upset, angry, and confused by a parent's suicidal gestures, the child may also devalue his own self-worth. The child may reason that if the parent is willing to attempt to kill herself in spite of the fact that she has children, then the parent must not care very much for the children. While the suicidal mother with MPD may believe that the child is better off without her as a mother, the child may feel neglected, abandoned, or rejected.

Often suicidality leads to hospitalization and separation from the family. Depending on the age of the child, prolonged or repeated separations can leave lasting effects and interfere with secure attachment.

Other Factors

1) *Child Abuse.* Kluft (1987) found that 16% of his sample of mothers had been grossly abusive to their children. Van der Kolk (1989) observed that adult males who have been recipients of early abuse and deprivation tend to be hyperaggressive, while adult females tend not to protect themselves or their young from danger. Chronic physiologic hyperarousal prevents the adult who has been traumatized in childhood from making rational assessments of situations. Rather than thinking to differentiate between present and past stimuli, the individual responds in an instinctive fashion as though the ancient trauma were being repeated. Stressful situations may discharge stimuli that remind the trauma survivor of the old traumas. Certainly, parenthood can be particularly stressful at times. The many pressures and strains inherent in rearing children can easily trigger old patterns of behavior in parents. These patterns may include hurting the self, hurting the child, or losing affect control.

   There is a large body of literature that indicates that child maltreatment is transgenerational, but there is some controversy over how many abused individuals repeat the abuse with their own children (Main & Goldwyn, 1984; Zeanah & Zeanah, 1989; Zaidi, Knutson, & Mehm, 1989; Kaufman & Ziegler, 1987; Leifer & Smith, 1990; Hunter & Kilstrom, 1979; McCord, 1982; Oliver, 1993). Chronic physical and/or sexual abuse of children is traumatic and impedes normal development (van der Kolk, 1989; Putnam, 1991; Cole & Putnam, 1992; Putnam & Trickett, 1993). Moreover, there is evidence that children of traumatized mothers with MPD are themselves at risk for developing MPD or other psychiatric disorders (Braun, 1985; Coons, 1985).

2) *Marital Issues.* The marital relationship has an impact on the well-being of children in a family. When there is hostility and negativity in the marital relationship, it bears upon the affective environment in the family. In dis-

tressed relationships, the high negative affect undermines parental effectiveness and children's development (Dix, 1991). Optimal outcomes for children in families in which one parent is manic-depressive occur when the other parent is not psychiatrically impaired (Davenport et al., 1984) or when the marital relationship is not distressed (DiNicola, 1989). Feldman & Guttman (1984) emphasized that in families in which one parent has a borderline personality, it is essential to mobilize the protective functions of the other parent.

A number of authors have studied the marriages of clients who suffer with a dissociative disorder (Sachs, 1986; Sachs, Frischholz, & Wood, 1988; Putnam, 1989; Panos, Panos, & Allred, 1990; Williams, 1991; Benjamin & Benjamin, 1992, 1994d, 1994f). Putnam (1989) suggested that MPD clients often marry mates with considerable psychopathology. We are in agreement with this assessment. As previously reported, we (Benjamin & Benjamin, 1994d) have formulated a typology of mates who seem drawn to MPD partners, and we have elaborated on the homeostatic patterns that characterize each. It is our belief that strengthening the marriage improves the outcome for therapy of the individual client. In cases where children are involved, a stronger, more harmonious marriage also enhances the child-rearing. Even when conflict between the partners predominates, we feel it is necessary that the partners cooperate in their co-parenting. A few authors (Silberman & Wheelan, 1980; Cohen & Weissman, 1984; Silberman, 1988) emphasized the parenting alliance in their approaches to parenting.

3) *Social Support.* A variety of authors have linked social support to better outcomes in child-rearing (Herrenkohl, 1978; Bronfenbrenner, 1979; Hunter & Kilstrom, 1979; Gabinet, 1983; Adamakos et al., 1986; Seagull, 1987; Giarretto, 1989; Corse, Schmid, & Trickett, 1990; Willett, Ayoub, & Robinson, 1991; Cochran, 1993). Often, parents with MPD feel very isolated and alone. In addition to family support, Sachs (1986) has recommended that clients with MPD find support through parenting programs, incest groups, assertiveness training groups, the clergy, peer networks, alcohol and substance abuse groups, leisure activity groups, tutorial groups, and 24-hour hotlines.

We believe that providing support for MPD mothers and their partners through groups in which the participants share similar situations can increase the potential for healthy child-rearing (Benjamin & Benjamin, 1992, 1994a, 1994b, 1994c, 1994d, in press). Other supports may include community and religious organizations, co-worker support through employment, and supports that provide direct care to children such as daycare and nursery programs.

CLINICAL IMPLICATIONS

Based on our review of the literature on parenting from the perspectives of psychodynamics, attachment, child devel-

opment, and family systems, we believe that an emphasis on parenting is a key element of the treatment of dissociative disorders. While traditionally individual psychodynamic psychotherapy facilitated by hypnosis is considered to be the treatment of choice, child and marital interventions are gaining wider acceptance. We believe that interventions in the parenting subsystem have been underutilized. They have the potential to increase optimal development for children, to facilitate the individual treatment of the MPD client, to strengthen the therapeutic alliance, and to stem the intergenerational transmission of child abuse.

Benefits from the Psychodynamic Perspective

Clients who were repeatedly traumatized while growing up often have difficulty trusting the therapist and the therapeutic process. Attending to a client's relationship with her children is less threatening than dealing with transference phenomena or making interpretations. The therapist's empathy for both the client and her children demonstrates early on that the therapeutic context is a safe one. As a trustworthy therapeutic relationship builds, the client indirectly works on developmental issues that are stirred up as she examines her own parenting.

When a therapist pays attention to a client-parent's parenting and helps the client feel more positive about mothering, the client is then free to introject and identify with the gratifying experience. Through this process, she may feel more self-confident about her own ability to mother.

Psychodynamic thinkers also view parenthood as an opportunity to rework childhood experiences and relationships with one's parents. Remembering the past (and especially the affect involved in past events) is helpful in the development of parental empathy. As empathy takes on a central role in the parent's relationship with her child, the parent is free to undertake the transformation of her own narcissistic tendencies into a new spiral of developing maturity. She can then begin to apply the same empathic processes in dealing with her own internal parts. In describing the therapist-client interaction, Kluft has wisely remarked in meetings of the Philadelphia Study Group (November 8, 1993 and other occasions) that "MPD is that mental disorder that dissolves in empathy." In a parallel process, the client can use this model to deal more empathically with a child as well as with the alters in the intrapsychic system.

Moreover, a resolution of childhood conflicts may facilitate the dissolution of boundaries among alters and thus aid ultimately in the path toward integration. It also has the potential to continue personality development through the formation of a healthier "parental self." This new image of herself as a competent parent may result in enhanced self-esteem for the client and thus further the process of healing and integration.

Benefits from the Attachment Perspective

Mothers with MPD are handicapped in their ability to promote secure attachments in their children. Their symptoms have the effect of keeping them emotionally or physically unavailable and/or of frightening or confusing their

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children. Certainly, parenting interventions, if they help parents understand attachment patterns and educate them to promote secure attachments in their own children, have the potential to stem the intergenerational transmission of an insecure attachment, if not a dissociative disorder. Liotti (1992) suggested that dissociative disorders could be prevented by providing "specifically tailored counseling services...to parents who are suffering from serious losses or other unresolved traumas while taking care of their infant children" (p. 202).

Additionally, Barach (1991) discussed how the dissociative client reenacts early attachment patterns within the therapeutic relationship. It makes sense, therefore, that the therapist-client relationship is a powerful resource for imparting the sense of a "secure base" to a client. The therapeutic context can provide an isomorphic bridge from therapy to the parent-child interaction.

Finally, in view of Rutter's (1974) position that the main attachment figure need not be the mother alone, ways should be found to promote other sources of attachment. These attachment figures might include the non-dissociative partner if he or she is sufficiently healthy, or other substitute parental figures from within or outside of the family.

Benefits from an Infant-Developmental Perspective

Dissociative disorders impede a parent's ability to sensitively tune in to the fine variations of a baby's behaviors and affects. While a miserable baby can distress any parent, a dissociative parent is at a distinct disadvantage because the parent's own ability to self-regulate is so tenuous.

Therapists can invite client-parents to bring infants to therapy so that they can observe the parent-infant interaction. Because client-parents often do not have "Representations of Interactions that have been Generalized" (Stern, 1985) of loving transactions between their own parents and themselves, they may benefit by watching the therapist interact with the baby. The therapist can also encourage the parenting partner to become "a self-regulating other" for the baby.

Benefits from an Affect Theory Perspective

Parents with MPD often either may have too little affect, too much affect, or affect that is mismatched with that of their child. Reducing negative affect is a first priority. Therapists can help parents examine unrealistic expectations and attributions that they have of their children. In the process, the client can get in touch with the unrealistic expectations and attributions that had been directed at her when she was growing up. That understanding can help the client-parent focus less on self-needs and more on the needs of the child. In the case of an overintrusive or overprotective parent, the therapist can help the parent to understand the origin of the over-intrusiveness/over-protectiveness, the effects on the parent, and the potential effects on the parent-child relationship. If the therapist helps the client-parent feel more competent in parenting, the parent may experience pleasure in parenting, thereby increasing her positive affect.

When the therapist works with both the marital and parental subsystems to increase mutual support and to help each parent find ways outside of therapy to garner support, positive affect may increase. Practical steps to better manage stress may also help to decrease negative affect.

The therapist's own modulation of affect with the client is, in fact, one of the most powerful interventions to influence the affect of the dissociative client. Affective matching is key to the client-parent's learning. With the client and her children together in the session, the therapist can model affect tolerance, modulation, and matching in ways that can be instructive to the client.

Benefits from a Family Systems Perspective

Obviously, an MPD parent does not have a well integrated sense of self, and frequently, the partner also has an impaired sense of self (Putnam, 1989; Benjamin & Benjamin, 1994d). The potential to triangulate a child into the marital relationship is great. Additionally, hostile parents can thrust a child into the predicament of having a split loyalty. Consequently, interventions in the marital dyad are important to tighten up generational boundaries and to resolve marital conflicts. Helping the parents to operate as a parenting team is crucial. The importance of the participation of the other partner cannot be overstated.

MPD parents often parentify or exploit their children because of destructive entitlement. Sensitizing them to the pernicious effects of their own childhood parentification and victimization can help them to appreciate that they have to take responsibility to not parentify or victimize their own children. If a parent is accountable to her children and she removes the burden of unfair treatment, she herself earns constructive entitlement or ethical credit (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Benjamin & Benjamin, 1992). Such a stance empowers the parent because she is effecting positive change for future generations.

Contextual therapists (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991) also emphasize that it is important for parents to encourage and validate children for contributing to the family in age-appropriate ways. Blocking children from giving can be just as destructive to children's sense of self-worth as forcing them to overgive through parentification. This kind of sensitivity to the ethical needs of children serves to build trust in the parent-child relationship.

From a therapeutic perspective, working in the parental subsystem gives the therapist additional leverage toward change. Boszormenyi-Nagy and colleagues (1981; 1991) stressed that this leverage is in the ethical realm. Parents are often motivated to makes changes in their lives because they feel accountable to their children. Including the children in family sessions, encouraging acknowledgement of the children's contributions to the family, and helping the parents explore how their relationship affects the children begin to deparentify the offspring.

CONCLUSION

In this article, we have attempted to understand parenting by reviewing several important theoretical perspectives. We have then utilized these various perspectives to sharpen our appreciation of how dissociative symptoms interfere with parenting. Finally, we have considered the clinical implications for the treatment of dissociative disorders raised by these theoretical points of view. However, we recognize that our conclusions are derived from theory and are untested by objective research. Empirical studies are necessary to test the relevance and validity of these concepts. ∎

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